STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
Plus 2	445033	A. BUILDING _____ B. WING _____	C 03/28/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NASHVILLE COMMUNITY CARE & REHABILITATION AT BORDE	1414 COUNTY HOSPITAL RD NASHVILLE, TN 37218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint investigation #43134, #43165, #43410, #43444, #43556, #43870, and #43959 was completed on 3/28/18 at Nashville Community Care & Rehabilitation at Bordeaux. No deficiencies were cited related to complaint investigation #43134, #43165, #43556, #43870, and #43959. Deficiencies were cited related to complaint investigation #43410, and #43444, and to infection control related to the medication administration under 42 CFR PART 483, Requirements for Long Term Care Facilities.	F 000	Nashville Community Care and Rehabilitation at Bordeaux does not believe and does not admit that any deficiencies existed before, during or after the survey. The facility reserves all rights to contest the survey findings through informal dispute resolution, formal appeals proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality Assurance or self-critical examination privilege which the facility does not waive and reserves the right to assert in any proceeding. The facility offers its response, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents.	
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on review of facility policy, medical record review, review of facility documentation, and staff interview, the facility failed to timely report an injury of unknown origin per policy to facility administration per facility policy; failed to implement facility policy related to training after an allegation of injury of unknown origin; and the facility administration failed to report the allegation of injury of unknown origin within 2	F 607		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Admin — (X6) DATE: 5/10/18

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Received 5-25-18

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F 607	Continued From page 1 hours to the State Agency (SA) per facility policy. Failing to implement abuse policies had the potential for abuse events to reoccur and put all 176 residents residing in the facility at risk. Findings include: Review of the facility "Abuse, Neglect and Misappropriation or Property," policy, revised 8/24/17, revealed the definition of an injury of unknown origin as: "...means an injury that meets both of the following conditions: (1) the source of the injury was not observed by any person, or the source of the injury could not be explained by the resident; and (2) the injury is suspicious because of the extent of the injury; or the location of the injury. Every Stakeholder, contractor and volunteer immediately shall report any allegation of abuse, injury of unknown source, or suspicion of crime. Directly after assuring that the resident(s) involved in the allegation or abuse event is safe and secure, the alleged perpetrator has been removed from the resident care area, and any needed medical interventions for the resident have been requested/obtained, the charge nurse will inform the Facility Administrator (the abuse coordinator), Director of Nursing [DON], physician and family or resident's representative of the allegation of abuse or suspicion of crime. The facility Administrator will determine whether the report constitutes an "allegation of abuse" or "suspicion of crime" as defined in this policy, and, if so, he or she, or the DON, will notify State agencies according to State reporting procedures within two hours. The Facility Administrator will investigate all allegations, reports, grievances, and incidents that potentially could constitute allegation of abuse, injuries of unknown source, exploitation,	F 607	F 607: 1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: a. Resident #10 was interviewed by the Social Services on 12/30/17. This observational interview didn't yield evidence of abuse. b. On 1/3/18 the alleged staff were suspended by the Administrator and terminated on 01/08/2018 for failure to report injury. 2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: a. On 12/30/17 nursing manangement completed skin assessments on residents with a BIMS less than 13 and Social Services interviewed residents with a BIMS of 13 and greater to assess for abuse. No issues noted. 3. What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur: a. On 5/10/18 the Regional Nurse Consultant re-educated the Administrator and Assistant Administrator	05/22/2018

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F 607	Continued From page 2 or suspicions of crime as defined in this account. The facility Administrator will make reasonable efforts to determine the root cause of the alleged violation, and will implement corrective action consistent with the investigation findings, and take steps to eliminate any ongoing danger to the resident or residents..." Medical record review revealed Resident #10 was admitted to the facility on 8/28/09 with diagnoses including Vascular Dementia, Psychosis, Adult Failure to Thrive, Osteoporosis, Muscle Wasting, and Atrophy. Medical record review of a Quarterly Minimum Data Set dated 12/28/17 revealed Resident #10 with severe cognitive impairment and no behaviors. Resident #10 required extensive assist of 1 person for bed mobility, dressing, and eating, and was dependent with 1 person assist for transfers, toilet needs, and bathing. Medical record review of a nursing assessment, completed by Licensed Practical Nurse (LPN) #7, dated 12/29/17 at 1:00 AM, revealed Resident #10 complained of pain and the LPN assessed the resident with swelling and pain in the right arm. The assessment did not indicate if the Administrator, or the DON were notified. Medical record review of a radiology report for Resident #10, dated 12/30/17 and faxed at 7:14 AM, revealed an acute mildly displaced distal humerus fracture. Medical record review of a "Nursing Progress Note," dated 12/30/17, written by LPN #7 revealed the night shift nurse reported an x-ray indicating a right arm fracture. The resident was	F 607	F 607 cont'd: on the facility abuse policy, investigation process and timely reporting of abuse allegations(including injury of unknown origins) within the mandated 2 hour time frame. b. On 4/2/18 the Talent Manager initiated re-education of staff on the facilitie's abuse policy which included reporting timeframe of 2 hours and reporting injuries of unknown origins. On 5/10/18 the facility sent the abuse policy and education material via USPS to staff that had not attended the abuse education session. A returned stamped envelope was also mailed out to ensure that staff returns signed acknowledged abuse policy. c. Licensed Nurses will conduct weekly skin assessments on facility residents in accordance with facility guidelines. Any skin issues identified as unknown in origin will be immediately investigated. d. An AD HOC QAPI meeting was conducted with the IDT and the medical director on 5/10/18 and the facility developed an action plan. 4. How will the corrective action will be	

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F 607	Continued From page 3 transported to the emergency room at 10:15 AM. The DON and Administrator were contacted as well (first observation of pain and swelling was on 12/29/17 at 1:00 AM). Medical record review of the emergency room "Progress Note," dated 12/30/17, revealed a right arm fracture that the physician documented "...was not a result of abuse/neglect..." Medical record review of a "Nursing Progress Note," dated 12/31/17 at 12:08 AM, revealed the "...resident returned from the hospital in no acute distress with a right arm splint and arm sling, family at bedside, and pain medication administered with good results..." Review of the facility interventions related to the investigation included "Abuse Education January 2018," which included 5 questions related to when to report abuse, signs of abuse, factors increasing the risk of abuse, and common reasons for abuse. Nurses were required to sign they received a copy of the "Signature Healthcare's Triage Process." Review of the sign-in sheets for the "Abuse Education 2018," revealed 137 of 285 listed staff had signed to indicate the training was completed. Review of the facility "Positioning Competency," revealed guidelines for assistance for a resident positioning in a bed and chair, and included areas to indicate completion, comments, employee signature, supervisor signature, and yes or no for successful completion. Review of the facility sign-off sheet included completed sign-off for all staff. Upon review of the individual competency sheets revealed multiple sheets were missing dates, evidence the competency was completed,	F 607	F 607 cont'd: monitored to ensure the deficient practice will not recur: The DON or designee will audit Event Manager in EMR(IHN) daily to ensure that events/incidents are completed, investigated and reporting to State Agency if applicable. Any issues with non-compliance will be presented to the QAA Comittee(Administrator, Asst. Administrator, DON, ICP nurse and Medical Director) for review and resolution.	

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F 607	Continued From page 4 and supervisor signatures. Interview with the DON on 3/28/18 at 1:00 PM in the Conference Room revealed when Certified Nurse Assistant (CNA) #9 came on shift at 11:00 PM the CNA discovered Resident #10 complaining of pain when being turned. CNA #9 reported the issue to LPN #7 and the resident was assessed with swelling and pain to the right arm. The Night Shift Supervisor/Registered Nurse (RN) #2 was notified and came to assess the resident. An x-ray was obtained with the results of a right arm fracture. Further interview confirmed the RN did not notify the DON or the Administrator per policy of the injury of unknown origin. Further interview confirmed the facility failed to report the injury of unknown origin to the SA within 2 hours as required and per policy. Interview with the Administrator on 3/28/18 at 1:35 PM in the Conference Room revealed he did not recall the time of notification of the incident. Further interview confirmed he called the DON on 12/30/17 after the x-ray results were received. Further interview revealed the facility began abuse training immediately on the day of discovery. When CNA #8 stated on 1/03/18 the injury might have occurred during positioning the facility felt the injury was caused by faulty positioning, and the facility began staff competencies for positioning. Since the emergency room physician did not think the injury was related to abuse/neglect the facility moved from an allegation of abuse to care competency. Further interview confirmed a delay in notification resulted in the facility not reporting the injury of unknown origin within 2 hours to the SA per facility policy. The Administrator confirmed the abuse training and positioning competencies for	F 607		

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F 607	Continued From page 5 nursing were not completed by the facility after the incident. Interview with the DON on 3/28/18 at 2:00 PM in the Conference Room confirmed the abuse training of when to report abuse was not completed for all staff and the positioning competencies were not completed for all nursing staff at the time of the investigation.	F 607		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the	F 609	F609 483.12(c)(1)(4) Reporting of Alleged Violations In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown origin, are reported immediately, but not later than 2 hours after the allegation is made. 1.Resident #10 is free from abuse as evidenced by observation conducted on 12/30/2017 by social services. The alleged staff were suspended on 01/03/2018 by the Administrator for the duration of the investigation and terminated as a result of failure to report injury. 2.Skin assessments (BIMS less than 13) were completed by nursing on 12/30/2017. All interviewable residents (BIMS 13 and above) have been interviewed by social services. There were no additional allegations of abuse or injuries of unknown	05/22/18

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F 609	Continued From page 6 incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on review of facility policy, medical record review,and staff interview, the facility failed to timely report an injury of unknown origin to the facility administration; and failed to notify the State Agency (SA) within 2 hours for 1 of 8 residents (Resident #10) reviewed for injury of unknown origin. Failing to report allegations of injury of unknown origin could increase the risk to all 176 residents residing in the facility. Findings include: Review of the undated facility "Abuse, Neglect and Misappropriation or Property" policy, revealed the definition of an injury of unknown origin as: "...means an injury that meets both of the following conditions: (1) the source of the injury was not observed by any person, or the source of the injury could not be explained by the resident; and (2) the injury is suspicious because of the extent of the injury; or the location of the injury. Every Stakeholder, contractor and volunteer immediately shall report any allegation of abuse, injury of unknown source, or suspicion of crime...the charge nurse will inform the Facility Administrator (the abuse coordinator), Director of Nursing [DON]...of the allegation of abuse...The facility Administrator will determine whether the report constitutes an "allegation of abuse" or "suspicion of crime" as defined in this policy, and, if so, he or she, or the DON, will notify State agencies according to State reporting procedures within two hours..." Medical record review revealed Resident #10 was	F 609	origin noted. 3.Administrator and Assistant Administrator were re-educated on the facility Abuse Policy, Investigation process, and timely reporting of all allegations within two hours on 05/10/2018 by the Regional Nurse Consultant. The facility will continue to follow the Abuse policy that includes thorough investigation and suspension and /or termination as needed and reporting to the state agency as necessary. Administration will complete or direct all steps of the investigation process (to include staff interviews, the completion of skin assessments to identify any injuries of unknown origin, development/revision of c are plans, behavior management education, etc.) If any skin injury is identified that appears to be suspicious with no origin, a member of the Nursing Administration team (or possible physician assessment if available) will assess the injury and identify the type of skin injury that is present and document the findings in the medical record. Staff education was initiated for all staff on 4/02/2018 (ongoing) by Nursing Administration related to Abuse, Neglect, Misappropriation, and Injuries of Unknown Origin. Education/In-service was also provided on the timely reporting of all allegations of abuse, neglect, misappropriation, and injuries of unknown origin.	

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F 609	Continued From page 7 admitted to the facility on 8/28/09 with diagnoses including Vascular Dementia, Unspecified Psychosis, Adult Failure to Thrive, Osteoporosis, Muscle Wasting, and Atrophy. Medical record review of the Quarterly Minimum Data Set dated 12/28/17, revealed Resident #10 with severe cognitive impairment, no behaviors, and requiring extensive assist of 1 person for bed mobility, dressing, and eating. Resident #10 was dependent with 1 person assist for transfers, toilet needs, and bathing. Medical record review of a nursing assessment, completed by Licensed Practical Nurse (LPN) #7, dated 12/29/17 at 1:00 AM, revealed Resident #10 complained of pain and the LPN assessed the resident with swelling and pain in the right arm. The assessment did not indicate if the Administrator, or the DON were notified. Medical record review of a radiology report for Resident #10, dated 12/30/17 and faxed at 7:14 AM, revealed an acute mildly displaced distal humerus fracture. Medical record review of a "Nursing Progress Note," dated 12/30/17, written by LPN #7 revealed the night shift nurse reported an x-ray indicating a right arm fracture. The resident was transported to the emergency room at 10:15 AM. The DON and Administrator were contacted as well (first observation of pain and swelling was on 12/29/17 at 1:00 AM). Review of the facility documentation report revealed the SA was notified on 12/30/17 at 1:35 PM, 36 1/2 hours after the event.	F 609	4.Nursing will conduct weekly skin assessments on all residents according to skin protocol. Any areas identified will prompt investigation to determine root cause. If origin in unknown, abuse protocol will be initiated. Social services will conduct interviews with 25 residents weekly x 2 weeks, then 10 residents weekly x 2 weeks or until substantial compliance is achieved. Any negative findings will be brought to the attention of administration immediately for further investigation and/or implementation of abuse protocol when warranted. Should there be an allegation of abuse through the resident interviews or skin assessments and once administration has determined a potential root cause or identified concerns that will initiate the abuse protocol, an all-staff in-service will be initiated immediately. 5.Nursing administration will review weekly skin assessments for any identified areas of concern. Administration will review resident interviews for any concerns that would warrant initiation of abuse protocol. An AdHoc QAPI meeting was conducted with the IDT and the medical director on 5/10/2018, and the facility developed an action plan. Any negative findings will be reported to the Quality Assurance committee weekly	

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F 609	Continued From page 8 Interview with the DON on 3/28/18 at 1:00 PM in the Conference Room revealed when CNA #9 came on duty at 11:00 PM Resident #10 complained of pain when being turned. CNA #9 reported the issue to LPN #7 and the resident was assessed with swelling and pain to the right arm. The Night Shift Supervisor/Registered Nurse (RN) #2 was notified and came to assess the resident. An x-ray was obtained with the results of a right arm fracture. Further interview confirmed the RN did not notify the DON or the Administrator per policy of the injury of unknown origin. Further interview confirmed the facility failed to report the injury of unknown origin to the SA within 2 hours as required and per policy. Interview with the Administrator on 3/28/18 at 1:35 PM in the Conference Room confirmed there was a delay in notification of the injury of unknown origin to administrative staff resulting in the facility's failure of not reporting the injury within two hours to the State Agency as required and per policy.	F 609	x 4 weeks, then monthly if compliance is maintained.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at	F 880	F880 483.80(a)(1)(2)(4)(e)(f) Infection Prevention and Control The facility must establish ad maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	05/22/18

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F 880	Continued From page 9 a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F 880	1.Resident #7 was discharged from facility on 12/27/2018. Facility is unable to correct documentation errors upon discharge. LPN #6 was educated by nursing administration on proper administration of medications for resident #15 to prevent the spread of infection. 2.All residents receiving medication has the potential to be affected by this deficient practice. ADON completed a 100% observational audit of all residents with PICC lines to ensure that dressings were changed according to facility guidelines All licensed nurses were re-educated by Talent Manager on PICC Line Dressing Change Protocol on 05/09/2018. Unit Managers will review physician telephone orders daily to check for new orders for PICC lines. They will check EZMAR to ensure that the telephone orders has been uploaded to EZMAR and placed on a schedule to be changed per facility guidelines. 3.Charge nurse #1 resigned from facility; therefore, no education was completed with this nurse. The talent manager re-educated all licensed nurses on medication administration and infection control processes. The ADON will conduct an observational audit of all residents with PICC lines as warranted by physician's orders to ensure	

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F 880	Continued From page 10 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on review of facility policies, medical record review, staff interview, and observation, the facility failed to ensure infection control measures related to the dressing change of a peripherally inserted intravenous catheter (PICC) for 1 of 3 residents (Resident #7) reviewed with PICC lines; and failed to properly utilize hand hygiene during medication administration for 1 of 4 residents (Resident #15) observed for medication administration. Failing to change PICC line dressings had the potential to affect eight residents identified with PICC lines; failing to use hand hygiene could increase the risk of infection, and had the potential to affect all 176 residents in the facility. Findings include: Review of facility "Infusion Therapy Procedures" dated 2011, was reviewed and revealed "...PICC and Midline Catheter dressing changes must be completed at minimum every seven days. Change immediately if: loose, not occlusive, moisture accumulation, drainage, redness, or	F 880	that the dressings are changed per facility guidelines. Any issues with non-compliance will be presented to the QAA Committee (DON, Administrator, Asst. Administrator, Medical Director, and Infection Control Prevention Nursing for review and resolution. 4.Pharmacy consultants completed medication pass observations the week of 5/7/2018 through 5/11/2018. The DON, ADON, and unit managers will observe 3 medication administration passes to include PICC line dressing changes weekly x 4 weeks, then random thereafter to ensure compliance. Any issues with noncompliance will be present the Quality Assurance Committee (Administrator, Assistant Administrator, Director of Nursing, Medical Director, and Infection Control Preventionist Nurse for review and resolution.	

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	445033	A. BUILDING _____ B. WING _____	C 03/28/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 11 irritation. Initial dressings will be changed PRN (as needed) if saturated, and 24-48 hours post insertion of Midlines, PICC's... if there is gauze present under the dressing or drainage is noted..." Medical record review revealed Resident #7 was admitted to the facility on 11/30/17 with diagnoses including Endocarditis. Further review revealed the resident was discharged home on 12/27/17. Medical record review of the Admission Minimum Data Set (MDS) dated 12/07/17 revealed Resident #7 was alert, oriented, and independent with all activities of daily living except assistance of 1 to be off the unit. Medical record review of the nursing admission assessment dated 11/30/17 revealed the resident was admitted with a right upper extremity PICC line. Medical record review of physician progress notes dated 11/30/17 revealed the resident was admitted for administration of intravenous antibiotics for Endocarditis. Medical record review of physician orders dated 11/30/17 through 12/10/17 revealed no order for a dressing change to the PICC line. Medical record review of a "Daily Skilled Nursing Note" dated 12/08/17 revealed "...central line dressing scheduled as per staff to be changed..." Medical record review of "Medication Administration Records," (MAR), dated 11/30/17 through 12/10/17 (11 days) revealed no evidence of a dressing change to the PICC line.	F 880		

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F 880	Continued From page 12 Medical record review of "Physician Orders" dated 12/10/17 for Resident #7 revealed "...discontinue PICC line and reinsert new Midline catheter..." Review of a "procedure form" for Resident #7 dated 12/10/17 revealed "...the patient PICC line was out 7 centimeters and the dressing was loose on three sides. A Midline catheter was inserted into the left upper arm with a dressing applied..." Medical record review of "Physician Orders" for Resident #7 dated 12/10/17 through 12/27/17 revealed no order for dressing change for the Midline catheter. Medical record review of the MAR for Resident #7 dated from 12/11/17 through 12/26/17 (17 days) revealed no evidence of a dressing change to the Midline catheter. Medical record review of the "Comprehensive Care Plan" dated 12/11/17, revealed the "...resident as at risk for complications related to the use of IV (intravenous) fluids and /or medications with a right upper arm PICC line..." Interventions included "...apply and check IV site treatment/dressings as ordered..." Interview with the Director of Nursing (DON) on 3/28/18 at 2:30 PM confirmed the resident was admitted with a PICC line. Further interview revealed the PICC line became misplaced and a new Midline catheter was placed to continue the antibiotic administration. The DON confirmed the facility failed to have documentation of a dressing change to the PICC line and Midline catheter	F 880		

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F 880	Continued From page 13 every seven days as per the facility policy. Review of the facility "Medication Administration General Guidelines" dated 2007 revealed, "...hands are washed with soap and water and gloves applied before administration of topical, ophthalmic, otic, parenteral, enteral, rectal, and vaginal medications. Hand are washed with soap and water again after administration and with any resident contact. Antimicrobial sanitizer may be used in place of soap and water as allowed per state nursing regulations and facility policy..." Medical record review revealed Resident #15 was admitted to the facility on 3/16/18 with diagnoses including Acute Respiratory Failure, Ventilator Dependent Status, and Respiratory Isolation for Pneumonia with Acinetobacter. Observation of medication administration on 3/27/18 at 8:50 AM revealed Licensed Practical Nurse (LPN) #6 entering the isolation room for Resident #15. LPN #6 donned personal protective equipment (PPE) to include a mask, gown, and gloves. With the help of Rehab #2 the resident was repositioned to allow better access to the resident gastronomy tub (G-tube). LPN #6 removed gloves, donned new gloves, and assessed the G-tube for placement and residual tube feed, changed gloves and administered several medications per the G-tube. LPN #6 then changed gloves and administered prescription eye drops in each eye. LPN #6 took off gloves and reached under the PPE gown and took a large bore needle from a uniform pocket, donned gloves and used the needle to puncture two fish oil capsules, and place the liquid from the capsules in a medication cup. After changing gloves, LPN #6 administered the fish oil through	F 880		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 880	Continued From page 14 the G-tube, changed gloves and administered a subcutaneous injection into the resident's abdomen. After changing gloves, LPN #6 administered a second drop of the prescription eye drop to each of the resident's eyes. LPN #6 then removed the PPE and gloves, washed hands with soap and water before exiting the room. The hand washing prior to exit was the only time LPN #6 completed hand washing or hand hygiene for the entire medication administration. Interview with LPN #6 on 3/27/18 at 9:30 AM on the second-floor hallway confirmed hand hygiene, to include hand washing or alcohol rub, was not used during the medication administration with Resident #15. Further interview revealed LPN#6 was unsure of the facility policy for hand hygiene. Interview with the DON on 3/28/18 at 5:10 PM in the facility Conference Room revealed staff were expected to wash hands or use alcohol rub any time gloves were worn and removed, before and after injections, and before eye drops and G-tube medications. Further interview confirmed nursing staff should not remove items from pockets while in an isolation room.	F 880		